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Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007

by David Rousseau, Lisa Clemans-Cope, Emily Lawton, Jessica Langston, John Connolly and Jhamirah Howard

Medicaid fills in the gaps in Medicare's benefit package for many low-income Medicare enrollees. These "dual eligibles" are individuals who are entitled to Medicare who are also eligible for some level of assistance from their state Medicaid program. Such assistance ranges from help paying for Medicare's premiums and cost-sharing, to coverage of benefits not offered under Medicare, such as hearing, vision, dental, and long-term care. Because dual eligibles have significant medical needs and a much higher per capita cost than other beneficiaries, they are of great interest to both Medicare and Medicaid policymakers and to the state and federal governments that finance and manage the programs.

This brief provides an update of the share of total Medicaid enrollment and spending attributable to dual eligibles using data through 2007. It also provides state-level estimates of Medicaid enrollment and expenditures for dual eligibles, together with a breakdown of dual eligible Medicaid expenditures by service category, as well as by age group and Medicaid eligibility group (elderly or disabled under age 65). Among the findings from this work are:

- Nearly **8.9 million** older Americans and younger persons with disabilities participated in both the Medicare and Medicaid programs in Federal Fiscal Year (FFY) 2007. Although these "dual eligibles" accounted for only **15 percent of Medicaid enrollment in 2007, 39 percent of all Medicaid expenditures** for medical services were made on their behalf. These same individuals also account for more than 25 percent of Medicare spending.[1]
- Dual eligibles as a share of total Medicaid enrollees **ranged from a low of 10 percent in Arizona and Utah to a high of 25 percent in Maine**, due to demographic differences and policy preferences across the states. Similarly, spending on dual eligibles as a percentage of total Medicaid spending ranged from a **low of 26 percent in Utah and New Mexico to a high of 59 percent in North Dakota.**
- **Nearly one quarter (24%) of Medicaid spending for dual eligibles went toward Medicare premiums and cost-sharing and other Medicare services in 2007.** Roughly five percent of spending for duals was for acute care services not covered by Medicare (e.g. dental, vision and hearing services). Another 1 percent of Medicaid dual eligible spending was for prescription drugs, a percentage that has fallen significantly since coverage for nearly all prescribed drugs for duals was shifted from Medicaid to Medicare Part D in 2006. The remaining **70% of Medicaid spending was for long-term care services** which are mostly not covered by Medicare or private insurance.
- Nearly **two-thirds of Medicaid spending on dual eligibles was for enrollees age 65 and older**. Although only 15 percent of dual eligibles were in an institutional long-term care setting in 2007, these enrollees accounted for more than half of all spending on duals. Like health spending more generally, **spending on dual eligibles is skewed toward those with the greatest health care needs** — the roughly 900,000 dual eligibles who were in the top ten percent of spending in 2007 accounted for more than 60 percent of all dual eligible spending.

Data Sources and Estimation Methods

Most data used in this analysis come from the federal fiscal year (FFY) 2007 Medicaid Statistical Information System (MSIS) maintained by the Centers for Medicare and Medicaid Services (CMS). The MSIS contains demographic, eligibility, and Medicaid expenditure information for every Medicaid enrollee. These source data are person-level and classify each individual's spending into 29 service categories. Enrollees were grouped into four broad eligibility categories: non-disabled adults, non-disabled children, disabled adults and children, and the elderly (all Medicaid enrollees over age 64). This paper focuses on individuals in the disabled and elderly categories, who we further classify as eligible for Medicaid only ("non-duals") or dually eligible ("duals").

All enrollment and eligibility calculations in this paper are based on the FFY 2007 MSIS. Data were limited to the 58.1 million enrollees that had valid information for broad eligibility category and that were not eligible through a special breast or cervical cancer program. From this base Medicaid population, dual eligibles were defined as beneficiaries that had valid dual information indicating dual eligibility and that were not missing age information. Of the total base population, there were 757 enrollees with missing dual eligibility information and an additional 15 enrollees that were missing age information. Total expenditures for these two missing groups were $5,422,743 and $156,030, respectively. Because the CMS Form 64 is regarded as a more accurate reflection of Medicaid program spending than the MSIS, we adjust MSIS-derived spending levels to those reported in 2007 on the CMS Form 64. In addition, MSIS data do not include premium payments that Medicaid makes to Medicare. Premium data from the CMS Form 64 are included in this analysis.

An Overview of FFY 2007 Dual Eligible Enrollment and Spending

Who are the Dual Eligibles?

Dual eligibles are individuals who are entitled to Medicare and are eligible for some level of assistance from their state Medicaid program. Categories of Medicare participants who are eligible to receive assistance under Medicaid are listed in Table 1. Some dual eligibles, referred to as "full" duals, qualify for one or more Medicaid benefits and receive assistance from Medicaid with their Medicare premiums and cost sharing. Other duals, referred to as "partial" duals, do not receive Medicaid benefits directly. For these duals, Medicaid provides "Medicare Savings Programs" through which enrollees receive assistance with some or all of their Medicare premiums, deductibles, and other cost-sharing requirements.[2]

Dual eligibles are among the sickest and poorest individuals covered by either Medicare or Medicaid. Most dual eligibles are very low-income individuals. In 2007, 57 percent of dual eligibles had annual incomes under $10,000, compared to 8 percent of non-dual Medicare beneficiaries. Only 6 percent of duals had annual incomes greater than $20,000. Fifteen percent required long-term care in a nursing facility. Fifty-two percent had difficulty with at least one instrumental activity of daily living (such as shopping, using the phone or managing money), and 44 percent had difficulty with at least one activity of daily living (such as dressing, bathing, or eating). The prevalence of many serious health conditions, such as cognitive or mental impairments, depression, and diabetes is significantly higher for duals than for non-duals.[3]

Table 1

Common Medicaid Eligibility Pathways for Medicare Beneficiaries

	Income Eligibility	Asset Limit	Medicaid Benefits in 2007
Individuals Eligible for Full Medicaid Benefits ("Full Dual Eligibles")			
SSI Cash-Assistance-Related (mandatory)	Generally 74% of the FPL for individuals and 82% of FPL for couples*[a]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Poverty-Related (optional)	Up to 100% of the FPL*[b]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Medically Needy (optional)	Individuals who spend down their incomes to state-specific levels.[b,c]	$2,000 (individual) $3,000 (couple)	"Wrap around" Medicaid benefits (may be more limited than those for SSI recipients). Medicaid may also pay Medicare premiums and cost sharing, depending on income.
Special Income Rule for Nursing Home Residents (optional)	Individuals living in institutions with incomes up to 300% of SSI.[d]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Home and Community Based Service Waivers (optional)	Individuals who would be eligible if they resided in an institution. Several states do not use the special income rule for waivers, so eligibility levels may be lower than 300% of SSI.		Full Medicaid benefits, including long-term care and prescription drugs, that 'wrap around' Medicare benefits. Medicaid may also pay Medicare premiums and cost sharing.
Medicare Savings Programs ("Partial Dual Eligibles")			
Qualified Medicare Beneficiaries[f] (QMB) (mandatory)	Up to 100% of the FPL*[b]	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare premiums (Part B and if needed, Part A) and cost sharing.[e]
Specified Low-Income Medicare Beneficiaries[f] (SLMB) (mandatory)	Between 100% and 120% of the FPL.*[b]	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare Part B premium.
Qualified Working Disabled Individuals (QWDI) (mandatory)	Working, disabled individuals with income up to 200% of the FPL.*	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare Part A premium.
Qualifying Individuals[g] (QI) (mandatory)	Between 120% and 135% of the FPL.*	$4,000 (individual) $6,000 (couple)[b]	No Medicaid benefits. Medicaid pays Medicare Part B premium. Federally funded, no state match. Participation may be limited by funding.

Source: Kaiser Commission on Medicaid and the Uninsured and Centers for Medicare and Medicaid Services (CMS).

* In 2007, 100% of the federal poverty level (FPL) was $851 for individuals and $1,141 for couples per month in the 48 contiguous states and the District of Columbia. Higher FPLs apply in Alaska and Hawaii.

a) The maximum federal SSI payment in 2007 was $623 per month for individuals and $934 per month for couples. People with incomes below these levels qualify for benefits. SSI disregards the first $20 of income from any source, plus the first $65 and half of all remaining earned income, so eligibility levels can be higher. However, few SSI recipients have earned income, so most qualify at or below the income levels shown. Some states using the "209(b) option" use different (often more restrictive) income or asset requirements for Medicaid eligibility for SSI recipients.

b) Section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are "less restrictive" than those that would otherwise apply, enabling states to expand eligibility above these standards.

c) Individuals eligible under the medically needy option have incomes that are too high to qualify under SSI or poverty-related levels. Unless their incomes fall below their state's medically needy standards for their family size, these individuals must incur sufficient medical expenses to reduce their income below those standards. Most states use medically needy income limits that are below SSI eligibility levels.

d) In 2007, 300% of SSI was $1,869 per month for an individual. Several states do not use the Special Income Rule, and a few other states use income limits that are below 300% of SSI.

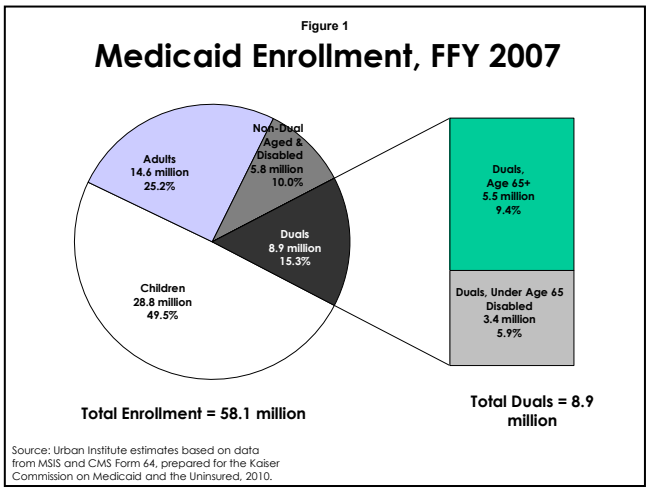
e) States are not required to pay for Medicare cost-sharing if the Medicaid payment rates for a given service are sufficiently lower than the Medicare payment rates.

f) QMB Plus and SLMB Plus categories were created when Congress changed eligibility criteria for QMBs and SLMBs to eliminate the requirement that QMBs and SLMBs could not otherwise qualify for Medicaid. Individuals in these "Plus" categories meet QMB or SLMB eligibility requirements, but also meet the financial criteria for full Medicaid coverage in their state. These individuals DO receive full Medicaid benefits.

g) Until September 30, 2002, Medicaid paid a small part of the Medicare Part B premium for additional Qualifying Individuals (QI2s) with incomes between 135% and 175% of the FPL. Congress allowed the authority for the QI2 program to expire on that date.

How Many Dual Eligibles are Enrolled in Medicaid?

Nearly 9 million Medicare beneficiaries were enrolled in Medicaid in 2007 (Table 2). This includes both those who received one or more full Medicaid benefits, "full" duals, and those who received only assistance with Medicare premiums and cost sharing, "partial" duals. These "partial" dual eligibles were not eligible for non-Medicare covered Medicaid services, such as hearing, vision, dental, and long-term care. Nearly one in six Medicaid enrollees (15 percent) was dually eligible in 2007 (Figure 1). Of these dual eligible enrollees, 6.9 million (77 percent) were "full" duals while the remaining 23 percent were "partial" duals.



While dual eligibles account for 15 percent of all Medicaid enrollees nationally, there is significant variation in their share of each state's Medicaid enrollment. Duals account for 25 percent of all Medicaid enrollees in Maine, and 22 percent in Alabama, North Dakota, and Wisconsin. In other states – Alaska, Arizona, California, New Mexico, and Utah – duals comprise 11 percent or less of the state's Medicaid enrollees. These variations reflect a state's demographic profile as well as state policy choices affecting the extent of Medicaid coverage they provide to their aged and disabled versus non-disabled adults and children. There is also great variation among states in the share of duals that receive full or partial Medicaid assistance. In states such as Delaware and Georgia, which cover many individuals through Medicare Savings Programs, roughly half of all dual eligibles in each state are "partial" dual eligibles. In states such as Alaska and California, on the other hand, where relatively fewer have been enrolled in Medicare Savings Programs, nearly all duals receive one or more full Medicaid benefits (Table 2).

Almost six in ten dual eligibles (5.5 million) were individuals age 65 and over, and just over three in ten (3.4 million) were younger persons with disabilities (Table 3). Only a small share (8 percent) of elderly Medicaid enrollees is not eligible for Medicare. These are individuals whose own or others' work histories were not sufficient to qualify them for Medicare.[4] A much larger share (61 percent) of Medicaid's non-elderly enrollees with disabilities do not meet eligibility criteria for Medicare, a significant portion of whom may be in the 2-year waiting period between first receiving federal Social Security Disability Insurance (SSDI) and becoming eligible for Medicare coverage.[5] As shown in Table 3, the percentage of aged enrollees that was dually eligible was as high as 99 to 100 percent in Iowa, Kentucky, Montana, North Dakota, South Carolina, South Dakota, and West Virginia. The share of disabled enrollees who were dual eligibles averaged 39 percent nationally, but the share was over 50 percent in Connecticut, Iowa, Maine, Nebraska, New Hampshire, North Dakota, and Vermont.

Table 2

Dual Eligibles and Full Dual Eligibles by State, 2007

State	Dual Eligibles	Duals as a Share of... All Medicaid Enrollees	Duals as a Share of... Aged and Disabled Enrollees	Full Dual Eligibles	Full Duals as a Share of All Dual Eligibles
United States	8,896,020	15%	60%	6,887,573	77%
Alabama	204,145	22%	64%	99,567	49%
Alaska	13,020	11%	56%	12,745	98%
Arizona	141,159	10%	62%	111,119	79%
Arkansas	99,375	14%	54%	68,580	69%
California	1,167,865	11%	61%	1,144,012	98%
Colorado	68,788	12%	55%	63,155	92%
Connecticut	100,257	19%	75%	76,938	77%
Delaware	22,942	12%	63%	10,888	47%
District of Columbia	21,852	13%	46%	18,923	87%
Florida	560,967	20%	65%	327,128	58%
Georgia	262,343	16%	62%	149,140	57%
Hawaii	31,927	15%	66%	29,385	92%
Idaho	30,317	14%	58%	21,700	72%
Illinois	304,346	13%	59%	267,640	88%
Indiana	149,447	15%	64%	95,979	64%
Iowa	79,303	17%	69%	66,481	84%
Kansas	62,097	18%	62%	47,118	76%
Kentucky	176,477	21%	57%	112,243	64%
Louisiana	182,015	17%	58%	106,870	59%
Maine	88,660	25%	76%	53,564	60%
Maryland	108,122	14%	54%	74,421	69%
Massachusetts	250,744	18%	43%	240,464	96%
Michigan	257,837	14%	58%	226,743	88%
Minnesota	129,160	16%	62%	117,691	91%
Mississippi	149,494	20%	60%	77,891	52%
Missouri	169,391	17%	62%	154,737	91%
Montana	18,051	16%	60%	15,584	86%
Nebraska	41,301	17%	71%	37,593	91%
Nevada	38,412	16%	63%	21,542	56%
New Hampshire	27,773	19%	74%	20,544	74%
New Jersey	200,442	21%	65%	166,435	83%
New Mexico	53,342	11%	58%	37,880	71%
New York	723,565	15%	61%	653,122	90%
North Carolina	305,904	19%	65%	248,468	81%
North Dakota	15,243	22%	76%	11,580	76%
Ohio	290,634	14%	54%	196,607	68%
Oklahoma	111,156	15%	65%	93,309	84%
Oregon	87,672	17%	66%	61,313	70%
Pennsylvania	380,676	18%	51%	323,856	85%
Rhode Island	39,236	20%	60%	34,008	87%
South Carolina	149,211	17%	66%	131,090	88%
South Dakota	20,257	17%	70%	13,798	68%
Tennessee	275,737	19%	62%	208,802	76%
Texas	609,468	15%	63%	380,594	62%
Utah	30,280	10%	59%	27,295	90%
Vermont	31,217	20%	75%	19,795	63%
Virginia	167,845	19%	64%	117,758	70%
Washington	144,224	12%	55%	109,833	76%
West Virginia	77,258	20%	52%	48,818	63%
Wisconsin	215,227	22%	73%	126,107	59%
Wyoming	9,839	13%	64%	6,720	68%

Source: Urban Institute and KCMU estimates based on data from MSIS 2007.

Table 3

Aged and Disabled Dual Eligibles by State, 2007

State	Aged Dual Eligibles	Aged Duals as a Share of … All Dual Enrollees	Aged Duals as a Share of … Aged Enrollees	Disabled Dual Eligibles	Disabled Duals as a Share of. . . All Dual Enrollees	Disabled Duals as a Share of. . . Disabled Enrollees
United States	5,481,054	62%	92%	3,414,966	38%	39%
Alabama	122,126	60%	98%	82,019	40%	42%
Alaska	7,187	55%	85%	5,833	45%	39%
Arizona	82,781	59%	91%	58,378	41%	42%
Arkansas	56,887	57%	88%	42,488	43%	35%
California	829,066	71%	87%	338,799	29%	35%
Colorado	43,179	63%	89%	25,609	37%	33%
Connecticut	61,975	62%	94%	38,282	38%	56%
Delaware	13,023	57%	94%	9,919	43%	45%
District of Columbia	13,310	61%	91%	8,542	39%	26%
Florida	375,995	67%	94%	184,972	33%	39%
Georgia	160,005	61%	96%	102,338	39%	40%
Hawaii	22,215	70%	97%	9,712	30%	39%
Idaho	15,541	51%	96%	14,776	49%	41%
Illinois	177,109	58%	81%	127,237	42%	43%
Indiana	77,552	52%	95%	71,895	48%	47%
Iowa	41,948	53%	99%	37,355	47%	52%
Kansas	33,263	54%	94%	28,834	46%	45%
Kentucky	95,075	54%	99%	81,402	46%	38%
Louisiana	110,136	61%	98%	71,879	39%	36%
Maine	54,307	61%	98%	34,353	39%	56%
Maryland	64,617	60%	89%	43,505	40%	34%
Massachusetts	136,577	54%	86%	114,167	46%	27%
Michigan	133,051	52%	98%	124,786	48%	41%
Minnesota	73,268	57%	78%	55,892	43%	49%
Mississippi	89,440	60%	96%	60,054	40%	38%
Missouri	88,359	52%	94%	81,032	48%	46%
Montana	10,370	57%	99%	7,681	43%	39%
Nebraska	22,797	55%	94%	18,504	45%	54%
Nevada	23,495	61%	97%	14,917	39%	40%
New Hampshire	13,954	50%	95%	13,819	50%	60%
New Jersey	134,199	67%	92%	66,243	33%	41%
New Mexico	33,419	63%	96%	19,923	37%	35%
New York	502,672	69%	90%	220,893	31%	35%
North Carolina	179,217	59%	98%	126,687	41%	44%
North Dakota	9,238	61%	99%	6,005	39%	57%
Ohio	153,732	53%	86%	136,902	47%	38%
Oklahoma	64,532	58%	97%	46,624	42%	45%
Oregon	49,723	57%	97%	37,949	43%	46%
Pennsylvania	219,298	58%	94%	161,378	42%	32%
Rhode Island	23,432	60%	95%	15,804	40%	39%
South Carolina	84,399	57%	100%	64,812	43%	46%
South Dakota	12,399	61%	99%	7,858	39%	47%
Tennessee	143,649	52%	96%	132,088	48%	45%
Texas	414,703	68%	97%	194,765	32%	36%
Utah	14,446	48%	95%	15,834	52%	44%
Vermont	19,373	62%	97%	11,844	38%	55%
Virginia	98,490	59%	95%	69,355	41%	44%
Washington	79,218	55%	91%	65,006	45%	37%
West Virginia	39,885	52%	99%	37,373	48%	34%
Wisconsin	150,987	70%	98%	64,240	30%	45%
Wyoming	5,435	55%	98%	4,404	45%	45%

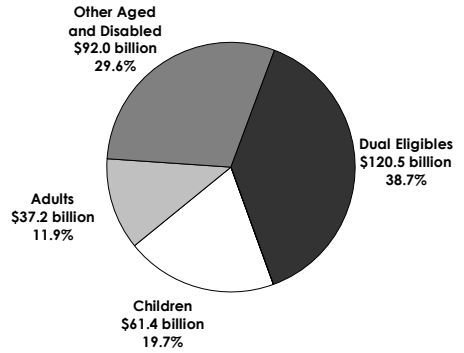
Source: Urban Institute and KCMU estimates based on data from MSIS 2007.

How Much Does Medicaid Spend on Services for Dual Eligibles?

Dual eligibles account for 15 percent of Medicaid enrollment, and due to their more intensive need for services, 39 percent ($120.5 billion) of all Medicaid expenditures for medical services (including Medicare premiums) were made on their behalf in 2007 (Table 4a and Figure 2). Again, duals' share of total spending and the way spending on dual eligibles was distributed across covered services varied significantly across the states. Spending on dual eligibles accounted for at least half of Medicaid spending in Connecticut, New Hampshire, North Dakota, and Wisconsin. Seventy percent of Medicaid expenditures for dual eligibles ($84.5 billion) were for long-term care services (Figure 3). Long-term care spending comprised more than 80 percent of spending on dual eligibles in Connecticut, Delaware, New Hampshire, North Dakota, Pennsylvania, and Vermont (Table 4b).

Figure 2

Medicaid Spending by Group, Services Only[1], FFY 2007



Total Spending = $311.0 billion

Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

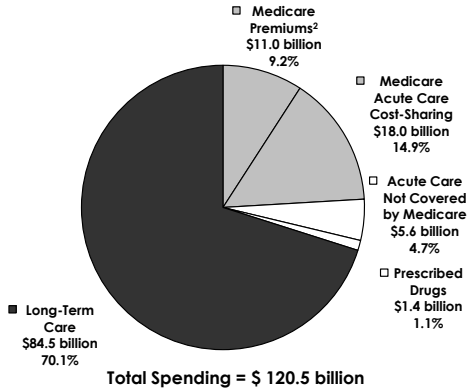
1. Expenditures include Medicare premiums as well as incomplete spending for Arizona.

Only 1 percent of 2007 expenditures for dual eligibles ($1.4 billion) were for prescription drugs. As noted above, nearly all prescription drug spending for dual eligibles was absorbed into Medicare in January 2006 with the implementation of Medicare Part D. However, states are required to make a substantial contribution towards this benefit through monthly "clawback" payments to the federal treasury.[6]

Another $29 billion in expenditures on dual eligibles went toward Medicare premiums and Medicaid's financing of Medicare-covered acute care services (e.g., hospital, physician, and lab/x-ray services). Finally, approximately $6 billion was spent for other acute care services that are not covered by Medicare, such as dental care, vision and hearing services.

Figure 3

Medicaid Expenditures for Dual Eligibles, FFY 2007[1]



Total Spending = $ 120.5 billion

Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

1. Expenditures include incomplete spending for Arizona.

2. "Medicare Premiums" also includes cost-sharing for Qualified Medicare Beneficiaries only.

Table 4a

Medicaid Expenditures for Dual Eligibles by State, 2007

State	Dual Eligible Total	Expenditures for Duals by Service (in Millions): Medicare Premiums[1]	Medicare Acute Care Cost-Sharing	Acute Care Not Covered by Medicare	Prescribed Drugs	Long-Term Care	Dual Eligible Spending as % of Total Medicaid	Spending Per Dual Eligible Per Year
United States[2]	$120,520	$10,899	$17,966	$5,624	$1,378	$84,511	39%	$15,459
Alabama	1,635	210	247	25	15	1,137	43%	8,947
Alaska	255	17	28	20	3	188	27%	22,496
Arizona[3]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Arkansas	1,438	237	303	137	11	749	46%	16,519
California	13,952	1,768	3,155	435	217	8,378	40%	13,304
Colorado	1,150	77	159	33	9	873	41%	19,774
Connecticut	2,359	200	303	-151	37	1,970	58%	26,953
Delaware	358	24	31	11	2	290	35%	17,576
District of Columbia	411	20	39	111	3	238	31%	21,636
Florida	5,253	907	856	111	42	3,337	38%	10,935
Georgia	1,869	231	285	104	23	1,226	28%	8,109
Hawaii	416	48	55	14	6	293	37%	15,221
Idaho	383	29	47	29	3	275	34%	14,435
Illinois	3,597	278	697	250	43	2,329	28%	13,458
Indiana	1,866	119	264	67	21	1,395	38%	14,930
Iowa	1,261	156	109	67	10	920	49%	18,389
Kansas	936	59	107	32	8	729	44%	17,676
Kentucky	1,561	170	220	27	36	1,107	34%	10,236
Louisiana	1,626	197	187	44	29	1,169	35%	10,282
Maine	961	76	52	195	11	626	48%	13,310
Maryland	1,886	141	268	52	11	1,413	35%	20,347
Massachusetts	4,760	324	720	814	37	2,865	44%	21,479
Michigan	3,285	335	697	68	28	2,157	37%	14,826
Minnesota	2,949	130	645	72	14	2,089	48%	26,578
Mississippi	1,281	107	154	75	8	937	40%	9,531
Missouri	2,253	262	373	206	37	1,375	37%	15,864
Montana	336	33	26	12	2	262	45%	23,051
Nebraska	705	84	84	20	9	508	46%	19,741
Nevada	389	55	48	18	5	263	33%	12,128
New Hampshire	490	14	56	8	4	408	50%	21,494
New Jersey	3,764	267	333	240	44	2,879	49%	20,812
New Mexico	682	56	71	29	2	524	26%	14,537
New York	19,159	1,024	2,491	712	146	14,785	45%	30,384
North Carolina	3,312	338	343	324	48	2,259	34%	12,121
North Dakota	305	9	20	3	1	272	59%	23,556
Ohio	4,873	287	497	141	64	3,883	40%	19,677
Oklahoma	1,214	110	172	34	11	887	36%	12,664
Oregon	1,142	90	170	35	9	838	40%	15,064
Pennsylvania	6,541	422	455	80	39	5,545	43%	19,884
Rhode Island	762	30	130	79	6	516	44%	22,105
South Carolina	1,427	136	357	33	24	878	37%	10,727
South Dakota	252	22	28	3	2	197	40%	14,258
Tennessee	2,385	292	414	32	20	1,627	33%	9,536
Texas	6,014	785	810	697	73	3,650	30%	10,797
Utah	361	26	68	10	9	248	26%	14,129
Vermont	408	7	24	33	10	335	48%	15,190
Virginia	2,030	182	226	23	19	1,580	42%	13,843
Washington	1,920	192	156	95	29	1,448	34%	15,722
West Virginia	823	85	58	16	13	651	37%	12,371
Wisconsin	2,748	221	486	91	120	1,831	55%	14,542
Wyoming	196	9	38	2	1	146	44%	23,516

Source: Urban Institute estimates based on data from MSIS 2007 and CMS Form 64.

1. The "Medicare Premiums" column also includes cost-sharing for Qualified Medicare Beneficiaries only.

2. The national totals include incomplete spending for Arizona.

3. For the current release of the MSIS 2007 data, the data quality for the state of Arizona is not adequate to construct measures of complete spending in the state. In addition, expenditures for Arizona are not shown by service because most expenditures for duals in Arizona are covered under the Arizona Long-Term Care System (ALTCS), which is a capitated program, and cannot be separated out by service type.

Table 4b

Medicaid Expenditures for Dual Eligibles by State, 2007

	Distribution of Spending for Dual Eligibles by Service					
State	Medicare Premiums[1]	Medicare Acute Care Cost-Sharing	Acute Care Not Covered by Medicare	Prescribed Drugs	Long-Term Care	Total
United States[2]	9%	15%	5%	1%	70%	100%
Alabama	13%	15%	2%	1%	70%	100%
Alaska	7%	11%	8%	1%	74%	100%
Arizona[3]	N/A	N/A	N/A	N/A	N/A	N/A
Arkansas	16%	21%	10%	1%	52%	100%
California	13%	23%	3%	2%	60%	100%
Colorado	7%	14%	3%	1%	76%	100%
Connecticut	8%	13%	-6%	2%	84%	100%
Delaware	7%	9%	3%	1%	81%	100%
District of Columbia	5%	9%	27%	1%	58%	100%
Florida	17%	16%	2%	1%	64%	100%
Georgia	12%	15%	6%	1%	66%	100%
Hawaii	12%	13%	3%	1%	70%	100%
Idaho	7%	12%	7%	1%	72%	100%
Illinois	8%	19%	7%	1%	65%	100%
Indiana	6%	14%	4%	1%	75%	100%
Iowa	12%	9%	5%	1%	73%	100%
Kansas	6%	11%	3%	1%	78%	100%
Kentucky	11%	14%	2%	2%	71%	100%
Louisiana	12%	12%	3%	2%	72%	100%
Maine	8%	5%	20%	1%	65%	100%
Maryland	7%	14%	3%	1%	75%	100%
Massachusetts	7%	15%	17%	1%	60%	100%
Michigan	10%	21%	2%	1%	66%	100%
Minnesota	4%	22%	2%	0%	71%	100%
Mississippi	8%	12%	6%	1%	73%	100%
Missouri	12%	17%	9%	2%	61%	100%
Montana	10%	8%	4%	1%	78%	100%
Nebraska	12%	12%	3%	1%	72%	100%
Nevada	14%	12%	5%	1%	68%	100%
New Hampshire	3%	11%	2%	1%	83%	100%
New Jersey	7%	9%	6%	1%	76%	100%
New Mexico	8%	10%	4%	0%	77%	100%
New York	5%	13%	4%	1%	77%	100%
North Carolina	10%	10%	10%	1%	68%	100%
North Dakota	3%	6%	1%	0%	89%	100%
Ohio	6%	10%	3%	1%	80%	100%
Oklahoma	9%	14%	3%	1%	73%	100%
Oregon	8%	15%	3%	1%	73%	100%
Pennsylvania	6%	7%	1%	1%	85%	100%
Rhode Island	4%	17%	10%	1%	68%	100%
South Carolina	10%	25%	2%	2%	62%	100%
South Dakota	9%	11%	1%	1%	78%	100%
Tennessee	12%	17%	1%	1%	68%	100%
Texas	13%	13%	12%	1%	61%	100%
Utah	7%	19%	3%	3%	69%	100%
Vermont	2%	6%	8%	2%	82%	100%
Virginia	9%	11%	1%	1%	78%	100%
Washington	10%	8%	5%	2%	75%	100%
West Virginia	10%	7%	2%	2%	79%	100%
Wisconsin	8%	18%	3%	4%	67%	100%
Wyoming	5%	19%	1%	1%	74%	100%

Source: Urban Institute estimates based on data from MSIS 2007 and CMS Form 64.

1. The "Medicare Premiums" column also includes cost-sharing for Qualified Medicare Beneficiaries only.

2. The national totals include incomplete spending for Arizona.

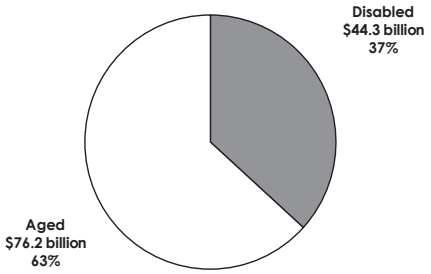
3. For the current release of the MSIS 2007 data, the data quality for the state of Arizona is not adequate to construct measures of complete spending in the state. In addition, expenditures for Arizona are not shown by service because most expenditures for duals in Arizona are covered under the Arizona Long-Term Care System (ALTCS), which is a capitated program, and cannot be separated out by service type.

Medicaid spending per dual eligible per year (which reflects spending per full-year-equivalent, dual eligible enrollee) averaged $15,459 for the nation in 2007 (Table 4a). However, several states – Connecticut, Minnesota, and New York – averaged more than $25,000 per dual eligible per year. Each of these states spent a larger than average share of total dual eligible spending on long-term care; as noted above, Connecticut, Delaware, New Hampshire, North Dakota, Pennsylvania, and Vermont spent over 80 percent of funding for duals on long-term care services (Table 4b). However, the range of per capita spending on a per enrollee, per year basis is wide. Several states – Alabama, Georgia, Mississippi, and Tennessee – spent less than $10,000 per dual eligible per year in 2007.

Sixty-three percent of total Medicaid spending on dual eligibles is for aged beneficiaries. Table 5 and Figure 4 show spending on aged and younger disabled dual eligibles. Spending per aged dual eligible per year is slightly higher than spending per disabled dual per year. Even when looking within eligibility groups, the range of per capita spending on dual eligibles is wide. Spending per aged dual per year ranged from more than $25,000 in Connecticut, Montana, New York, and Pennsylvania to less than $10,000 in Georgia and Louisiana. Among disabled duals, per capita spending ranged from more than $35,000 in New York to under $7,000 in Alabama and Georgia.

Figure 4

Distribution of Medicaid Expenditures Among Aged and Disabled Dual Eligibles, FFY 2007[1]



Total Spending = $ 120.5 billion

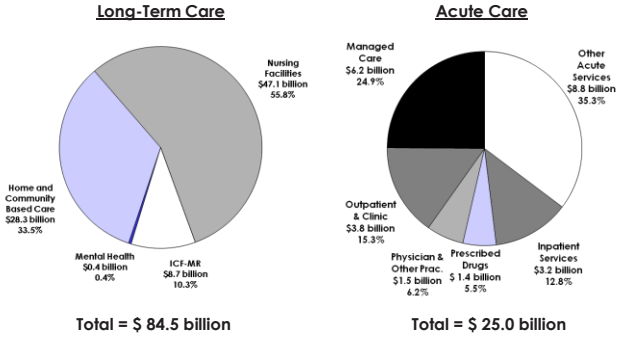
Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

1. Expenditures include incomplete spending for Arizona.
Note: Medicare premium costs were allotted to aged and disabled eligibles based on their relative proportions of enrollees.

When Medicare premiums are excluded, 77 percent of Medicaid spending on duals in 2007 was for long-term care services. Table 6 and Figure 5 provide detailed data on expenditures by type of service (excluding Medicare premiums). Fifty-six percent of long-term care spending ($47.1 of $84.5 billion) was on nursing facilities. Most of the remaining long-term care spending was on home and personal care services. Prescription drugs accounted for 1 percent of spending on dual eligibles, which was a sharp decline from 17 percent of spending in 2005 (Figure 6). This drop resulted from the 2006 implementation of Medicare Part D. Other acute care services are also covered primarily by Medicare, which explains the relatively low spending on services such as inpatient and outpatient hospital and physician services.

Figure 5

Medicaid Spending by Type of Service for Dual Eligibles, FFY 2007[1]



Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

1. Expenditures include incomplete spending for Arizona.
Note: Does not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

Spending on services for duals under age sixty-five was greater for long-term care than for acute care services ($28.4 billion vs. $11.6 billion). Almost forty percent of spending on this group was for home and personal care services and another thirty-two percent was on long-term care in an institutional setting (ICF-MR or nursing facility).

Table 5

Medicaid Expenditures for Aged and Disabled Dual Eligibles by State, 2007 Expenditures

	Aged			Disabled		
State	Total (in millions)	Spending Per Aged Dual Eligible Per Year	Percent of Dual Eligible Expenditures	Total (in millions)	Spending Per Disabled Dual Eligible Per Year	Percent of Dual Eligible Expenditures
United States[1]	$76,243	$15,900	63%	$44,278	$14,755	37%
Alabama	1,150	10,415	70%	485	6,706	30%
Alaska	145	23,006	57%	110	21,853	43%
Arizona[2]	N/A	N/A	N/A	N/A	N/A	N/A
Arkansas	902	18,123	63%	535	14,373	37%
California	9,409	12,573	67%	4,543	15,125	33%
Colorado	725	20,068	63%	425	19,291	37%
Connecticut	1,480	27,619	63%	879	25,902	37%
Delaware	216	18,692	60%	142	16,110	40%
District of Columbia	258	22,081	63%	153	20,925	37%
Florida	3,728	11,503	71%	1,525	9,757	29%
Georgia	1,278	9,073	68%	591	6,594	32%
Hawaii	288	14,978	69%	129	15,794	31%
Idaho	206	15,540	54%	177	13,329	46%
Illinois	1,952	12,657	54%	1,645	14,551	46%
Indiana	1,036	16,315	56%	830	13,501	44%
Iowa	661	18,806	52%	600	17,950	48%
Kansas	513	18,568	55%	423	16,702	45%
Kentucky	976	11,751	63%	584	8,422	37%
Louisiana	935	9,771	57%	692	11,064	43%
Maine	578	13,686	60%	383	12,779	40%
Maryland	1,155	20,888	61%	731	19,547	39%
Massachusetts	2,876	24,274	60%	1,884	18,268	40%
Michigan	2,444	21,744	74%	841	7,704	26%
Minnesota	1,531	24,985	52%	1,418	28,544	48%
Mississippi	889	11,056	69%	393	7,263	31%
Missouri	1,278	17,199	57%	975	14,399	43%
Montana	242	29,673	72%	93	14,596	28%
Nebraska	395	20,537	56%	309	18,809	44%
Nevada	251	12,637	64%	138	11,302	36%
New Hampshire	259	22,988	53%	231	20,032	47%
New Jersey	2,373	19,673	63%	1,391	23,090	37%
New Mexico	406	13,726	60%	276	15,923	40%
New York	12,274	27,956	64%	6,885	35,951	36%
North Carolina	1,965	12,347	59%	1,347	11,806	41%
North Dakota	185	23,997	61%	120	22,905	39%
Ohio	2,823	21,730	58%	2,050	17,412	42%
Oklahoma	687	12,360	57%	527	13,082	43%
Oregon	776	18,341	68%	366	10,931	32%
Pennsylvania	4,872	26,057	74%	1,669	11,756	26%
Rhode Island	429	21,015	56%	333	23,687	44%
South Carolina	886	11,773	62%	541	9,366	38%
South Dakota	155	14,610	62%	96	13,724	38%
Tennessee	1,302	10,176	55%	1,083	8,866	45%
Texas	3,944	10,400	66%	2,071	11,644	34%
Utah	173	14,346	48%	188	13,936	52%
Vermont	242	14,456	59%	166	16,404	41%
Virginia	1,204	14,047	59%	826	13,556	41%
Washington	1,198	17,919	62%	722	13,065	38%
West Virginia	520	15,185	63%	303	9,390	37%
Wisconsin	1,738	13,183	63%	1,010	17,679	37%
Wyoming	102	22,606	52%	94	24,594	48%

Source: Urban Institute and KCMU estimates based on data from MSIS 2007 and CMS Form 64 .

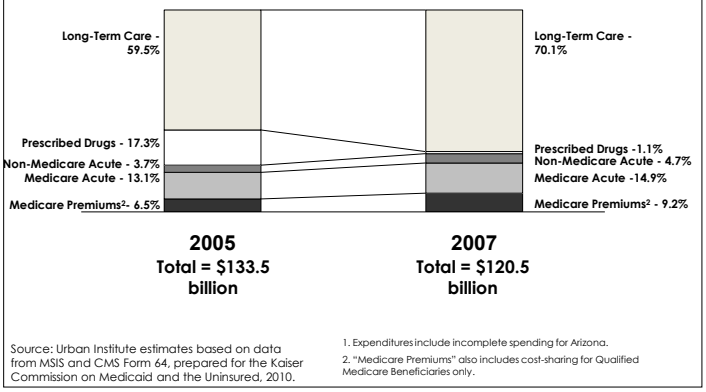
Note: Medicare premium expenditures were allotted based on the relative proportions of disabled and aged enrollees in the dual population.

1. The national totals include incomplete spending for Arizona.

2. For the current release of the MSIS 2007 data, the data quality for the state of Arizona is not adequate to construct measures of complete spending in the state. In addition, expenditures for Arizona are not shown by service because most expenditures for duals in Arizona are covered under the Arizona Long-Term Care System (ALTCS), which is a capitated program, and cannot be separated out by service type.

Figure 6

Distribution of Medicaid Expenditures for Dual Eligibles by Service, FFY 2005 and 2007[1]



Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

1. Expenditures include incomplete spending for Arizona.
2. "Medicare Premiums" also includes cost-sharing for Qualified Medicare Beneficiaries only.

Table 6

Medicaid Expenditures for Dual Eligibles by Type of Service and Age Group, 2007

Service/Service Group	Less Than 65 Years Old		65 to 75 Years Old		75 Years Old or Older		All		65 Years Old or Older	
	(in millions)		(in millions)		(in millions)		(in millions)		(in millions)	
Long-term Care Services	**$28,441**	**71%**	**$11,737**	**69%**	**$44,332**	**84%**	**$84,511**	**77%**	**$56,069**	**81%**
Nursing Facilities	5,258	13%	6,758	40%	35,114	67%	47,131	43%	41,873	60%
ICF-MR	7,527	19%	756	4%	393	1%	8,676	8%	1,149	2%
Mental Health	59	0%	191	1%	112	0%	363	0%	304	0%
Home and Personal Care	15,596	39%	4,031	24%	8,713	17%	28,340	26%	12,744	18%
Acute Care Services	**$11,597**	**29%**	**$5,171**	**31%**	**$8,199**	**16%**	**$24,968**	**23%**	**$13,370**	**19%**
Inpatient Services	1,432	4%	816	5%	944	2%	3,192	3%	1,760	3%
Prescribed Drugs	768	2%	319	2%	291	1%	1,378	1%	609	1%
Physician and Other Practitioners	820	2%	364	2%	364	1%	1,548	1%	728	1%
Outpatient and Clinic	2,469	6%	755	4%	603	1%	3,827	3%	1,358	2%
Managed Care	2,159	5%	1,437	8%	2,616	5%	6,212	6%	4,053	6%
Other Acute Services	3,949	10%	1,480	9%	3,382	6%	8,811	8%	4,862	7%
Total Spending	**$40,039**	**100%**	**$16,908**	**100%**	**$52,532**	**100%**	**$109,478**	**100%**	**$69,440**	**100%**

Spending Per Enrollee Per Year

Service/Service Group	Less Than 65 Years Old		65 to 75 Years Old		75 Years Old or Older		All		65 Years Old or Older	
Long-term Care Services	**$9,478**	**71%**	**$5,825**	**69%**	**$15,945**	**84%**	**$10,840**	**77%**	**$11,693**	**81%**
Nursing Facilities	1,752	13%	3,354	40%	12,630	67%	6,046	43%	8,733	60%
ICF-MR	2,508	19%	375	4%	141	1%	1,113	8%	240	2%
Mental Health	20	0%	95	1%	40	0%	47	0%	63	0%
Home and Personal Care	5,197	39%	2,001	24%	3,134	17%	3,635	26%	2,658	18%
Acute Care Services	**$3,865**	**29%**	**$2,566**	**31%**	**$2,949**	**16%**	**$3,203**	**23%**	**$2,788**	**19%**
Inpatient Services	477	4%	405	5%	339	2%	409	3%	367	3%
Prescribed Drugs	256	2%	158	2%	104	1%	177	1%	127	1%
Physician and Other Practitioners	273	2%	181	2%	131	1%	199	1%	152	1%
Outpatient and Clinic	823	6%	375	4%	217	1%	491	3%	283	2%
Managed Care	720	5%	713	8%	941	5%	797	6%	845	6%
Other Acute Services	1,316	10%	735	9%	1,217	6%	1,130	8%	1,014	7%
Total Spending Per Enrollee	**$13,342**	**100%**	**$8,392**	**100%**	**$18,895**	**100%**	**$14,043**	**100%**	**14,482**	**100%**

Source: Urban Institute and KCMU estimates based on MSIS 2007 and CMS Form 64.
Note: Expenditures do not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data. In addition, expenditures include incomplete spending for Arizona.

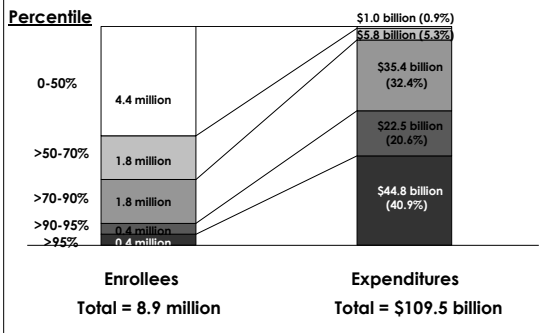
The remaining share was distributed among the various acute care services. The pattern was somewhat similar for duals between ages 65 and 75. The main exception was that spending on this age group was more concentrated in institutional rather than community-based, long-term care settings, with this age group more reliant on nursing facilities than on ICF-MR. For those 75 and over, 84 percent of expenditures were on long-term care services and the remainder on acute care services. Two-thirds of spending on those age 75 and over was on nursing home care. Overall, duals age 75 and over accounted for $52.5 billion in expenditures; those under age 65 accounted for $40.0 billion.

Per enrollee per year spending varies widely across age categories. On a per enrollee per year basis, spending for those 75 and over amounted to nearly $19,000 per year. Of this total, about $16,000 per year was spent on long-term care services, mostly for nursing home care. Those below the age of 65, i.e., the disabled, averaged more than $13,000 per enrollee per year. More than 70 percent of this spending was for long-term care services, and more than half of that (55% or $5,197) was for home and personal care services. Acute care services for disabled duals amounted to $3,865, more than acute care spending for the older age groups. Prescription drugs not covered by Medicare Part D accounted for $256 of this spending. For those 65 to 75 years old, per enrollee per year spending was far lower, $8,392, reflecting a lower level of health care need compared to either the older group or those eligible due to disability.

Like health spending more generally, Medicaid spending on dual eligibles is skewed toward those with the greatest health care need. Past research has shown that relatively small numbers of Medicaid enrollees with very high spending account for a significant share of program spending.[7] Table 7 and Figure 7 demonstrate that spending on dual eligibles is highly concentrated, with the top 10 percent of spenders accounting for more than 60% of all spending, and the top 5% accounting for more than 40%. Spending for this small group of very high-cost duals totaled nearly $45 billion. This represents more than four in ten dollars spent on duals and more than one of eight dollars the Medicaid program spent in 2007. The 4.4 million dual eligibles in the bottom 50% of the spending distribution accounted for less than 1% of all Medicaid spending on dual eligibles.

Figure 7

Dual Eligible Enrollment and Medicaid Spending by Per Enrollee Spending Percentile, FFY 2007[1]



Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

1. Expenditures include incomplete spending for Arizona.

Note: Does not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

This skewed spending is illustrated in the percentile distributions of per capita spending on a per enrollee per year basis (Table 7). Dual eligibles above the 95th percentile of per enrollee per year spending had an average of $104,093 in Medicaid spending. Those in the 90 to 95th percentiles of spending had $52,902 in per enrollee per year spending, those in the 70th to 90th percentiles had $22,914 in per enrollee per year spending, and those in the 50th to 70th percentiles had $3,643 in per enrollee per year spending. The bottom 50% of spenders averaged just $253 in per enrollee per year Medicaid spending.

The 15 percent of dual eligibles who were in an institutional long-term care setting for some period of FFY 2007 accounted for more than half (56.7%) of all spending on duals and just over a fifth (20.7%) of all Medicaid expenditures. Duals with institutional spending spent an average of $55,214 per enrollee per year.

Table 7

Medicaid Enrollment and Expenditures for Dual Eligibles by Per Enrollee Spending Percentile, 2007

	Per Enrollee Expenditure Percentile	Enrollees (in thousands)	% of Dual Enrollees	% of All Enrollees	Expenditures (in millions)	% of Dual Expenditures	% of All Expenditures	Spending Per Enrollee Per Year
	United States	**8,896**	**100.0%**	**15.3%**	**$109,478**	**100.0%**	**36.5%**	**$14,043**
	>95%	445	5.0%	0.8%	44,823	40.9%	14.9%	104,093
ALL	>90-95%	445	5.0%	0.8%	22,513	20.6%	7.5%	52,902
DUALS	>70-90%	1,779	20.0%	3.1%	35,419	32.4%	11.8%	22,914
	>50-70%	1,779	20.0%	3.1%	5,758	5.3%	1.9%	3,643
	0-50%	4,448	50.0%	7.7%	967	0.9%	0.3%	253
	United States	**1,324**	**14.9%**	**2.3%**	**$62,084**	**56.7%**	**20.7%**	**$55,214**
	>95%	306	3.4%	0.5%	30,067	27.5%	10.0%	100,924
WITH	>90-95%	330	3.7%	0.6%	16,747	15.3%	5.6%	52,965
INSTITUTIONAL	>70-90%	586	6.6%	1.0%	14,910	13.6%	5.0%	32,865
CARE	>50-70%	88	1.0%	0.2%	363	0.3%	0.1%	7,495
	0-50%	14	0.2%	0.0%	0	0.0%	0.0%	0
	United States	**7,572**	**85.1%**	**13.0%**	**$47,394**	**43.3%**	**15.8%**	**$7,104**
	>95%	138	1.6%	0.2%	14,757	13.5%	4.9%	111,208
WITHOUT	>90-95%	115	1.3%	0.2%	5,767	5.3%	1.9%	52,720
INSTITUTIONAL	>70-90%	1,193	13.4%	2.1%	20,509	18.7%	6.8%	18,780
CARE	>50-70%	1,691	19.0%	2.9%	5,395	4.9%	1.8%	3,522
	0-50%	4,434	49.8%	7.6%	967	0.9%	0.3%	254

Source: Urban Institute and KCMU estimates based on MSIS 2007.

Note: Expenditures do not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data. In addition, expenditures include incomplete spending for Arizona.

However, 85 percent of duals never lived in an institutional setting in 2007. These individuals accounted for the remaining 43.3 percent of dual expenditures and 15.8 percent of total Medicaid program spending. Medicaid spending in this group averaged $7,104 per enrollee per year in 2007.

Looking Forward

Dual eligibles are among the sickest and poorest individuals covered by either the Medicaid or Medicare programs. This brief documents that 39% of all Medicaid spending in FFY 2007 was on behalf of the 8.9 million Medicare enrollees who qualified for both programs. Previous research has demonstrated that combined per capita Medicaid and Medicare spending is much higher for dual eligibles than for non-duals ($20,902 vs. $4,553 in 2003).[8]

There exists significant variation in the dual eligibles' share of total Medicaid spending and enrollment across the states, reflecting both variation in states' demographic profiles as well as state policy choices affecting the extent of Medicaid coverage provided to the aged and disabled versus non-disabled adults and children.

Discussions of strategies to address spending growth in both programs invariably include dual eligibles due to their high costs, complex health needs, and unique reliance on both programs.

However, these strategies also need to take into account a challenging array of physical and mental health issues uncommon in other populations, together with service delivery systems that are often challenged by Medicaid and Medicare's bifurcated financing structure. Efforts to improve care delivery for this population require adequate safeguards to ensure that this fragile population does not experience unavoidable disruptions in their care. Recognition also needs to be given to the challenge of reducing the heavy reliance of dual eligibles on institutional care, particularly among those seniors over age 75.

Much of Medicaid's spending on dual eligibles (70%) was for long-term care services, which generally are not covered by Medicare or private insurance and have high ongoing rather than episodic costs. Some states have been moving forward with efforts to improve integration of care for this population, including providing new options for beneficiaries who are in need of long-term services and supports to receive such services while remaining in their community, thereby reducing reliance on institutional care.

The recently enacted health reform law further encourages this shift and creates several new initiatives that may help improve coordination of acute and long term care for Medicare and Medicaid dual eligibles.[9] The Patient Protection and Affordable Care Act (ACA) establishes two new federal entities that will be involved in efforts to study and improve care for dual eligible beneficiaries: the Federal Coordinated Health Care Office and the Center for Medicare and Medicaid Innovation (CMMI), both housed within the Center for Medicare and Medicaid Services (CMS). The Federal Coordinated Health Care Office will bring together staff from the Medicare and Medicaid programs within CMS to improve coordination between Medicare and Medicaid, and the federal government and the states. This office is charged with ensuring that dual eligibles have full access to the benefits and long term services to which they are entitled under the Medicare and Medicaid programs. In addition to the Federal Coordinated Health Care Office, the CMMI will test innovative payment and delivery models to lower costs and improve quality for all Medicare and Medicaid beneficiaries, including the dual eligibles.

Given their complex health needs, high level of spending, and use of long term services and supports, dual eligibles will continue to be a focus of state and federal policy. Improving care coordination and payment structures across the range of acute and long term services for dual eligibles while assuring beneficiary safeguards will be an essential component of efforts to strengthen both the Medicare and Medicaid programs in the years ahead.

David Rousseau, John Connolly, and Jhamirah Howard are analysts with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Lisa Clemans-Cope, Emily Lawton, and Jessica Langston are researchers at the Urban Institute.

Notes

[1] Medpac. "A Data Book: Healthcare Spending and the Medicare Program." Section 3, June 2010. Available online at http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf. According to Medpac, dual eligibles accounted for 27% of program spending in 2006.

[2] Medicare consists of two types of coverage: Part A, which primarily covers inpatient care, and Part B, which pays for physician services, outpatient care, lab and x-ray services, durable medical equipment and some other services. Both Part A and B require participants to pay premiums, deductibles and coinsurance for services they receive.

[3] Kaiser Family Foundation analysis of the Centers for Medicare and Medicaid Services Medicare Current Beneficiary Survey, 2007 Access to Care file.

[4] Medicare eligibility generally requires an individual or his or her spouse to have paid Medicare payroll tax for at least 40 calendar quarters (10 years).

[5] Federal law requires permanently disabled individuals to wait for 24 months after beginning receipt of Social Security Disability Insurance (SSDI) before becoming eligible for Medicare coverage. A 2003 study estimated that 1.2 million disabled, non-elderly individuals (nearly 400,000 of whom were uninsured) were currently in the two-year waiting period, and that eliminating this waiting period would save states roughly $1.8 billion (Stacy Berg Dale and James Verdier, "Elimination of Medicare's Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs, the Commonwealth Fund, July 7, 2003).

[6] States also have the option of providing (and receiving federal matching funds for) Medicaid coverage of drugs that were explicitly excluded from Medicare Part D by statute. A list of these drugs or classes of drugs (with the exception of smoking cessation drugs, which are included under the Medicare prescription drug benefit) can be found in section 1927(d)(2) of the Social Security Act. For more information on state coverage of these excluded drugs, see https://www.cms.gov/Reimbursement/EDC/list.asp.

[7] Sommers A and M Cohen. 2006. "Medicaid's High Cost Enrollees: How Much Do They Drive Medicaid Spending?" Kaiser Commission on Medicaid and the Uninsured, March.

[8] See Coughlin et al. in *Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries*, KCMU, April 2009, available online at http://www.kff.org/medicaid/7895.cfm

[9] For more information on the ACA's long-term services and supports provisions, please see *Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law*, June 2010, available at http://www.kff.org/healthreform/upload/8079.pdf.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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